STATE OF HAWAII
Department of Human Services
Med-QUEST Division

# HAWAII Rx PLUS PROGRAM APPLICATION

| OFFICIAL USE ONLY |
|---|
| Date Received: _____ |
| Case No.: _____ |

**Purpose:** ☐ New Application or ☐ Reporting Change

**Please Type or Print Clearly**

**1. Please tell us who you are and where you live. Also write your name and information in number 2.**

| Last Name | First Name | Middle Initial | Daytime Phone Number |
|---|---|---|---|
| | | | |
| **Address (Where you live)** | **Apartment Number** | **City, State, and Zip Code** | **Nighttime Phone Number** |
| | | | |
| **Mailing Address (If it is different from where you live)** | | **City, State, and Zip Code** | **E-Mail Address** |
| | | | |

**2. Please tell us about yourself and who lives in your household.** List yourself first and use legal names. Write only family members who are responsible for each other, such as a spouse, dependent children under 19 years old, and the children's parents. The information will determine your household size. If there are more family members, please attach a separate sheet.

| Name (Last, First, Middle Initial) | Relationship to You | Date of Birth | Are you a resident of the State of Hawaii? | Are ALL your drugs paid by insurance? |
|---|---|---|---|---|
| same as above | Self | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Spouse | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |

**3. Please tell us ALL income your household got in the last 12 months (before deductions-not take home pay)** $_____
Income can be wages, self-employment income, Social Security benefits, supplemental insurance benefits (SSI), pension/retirement income, veteran's benefits, temporary disability insurance (TDI), workers compensation, unemployment insurance benefits (UIB), insurance settlements, school grants, loans, and scholarships, child support, alimony, child's income, etc.

**4. Please tell us that you read or had read to you the statement below by signing your name and writing the date.**
If the family members listed above include any person(s) 18 years or older, I certify that I am authorized by such person(s) to submit this application on his/her/their behalf.

I certify the information I have provided on this application is true to the best of my knowledge. If I intentionally make false statements on this application, I may be prosecuted under Hawaii Revised Statutes §710-1063. I give permission to the State of Hawaii to check my statements. I have read or had read to me the list of rights and responsibilities on the back of this page.

_____ _____
Applicant's Signature Date

**Hawaii Rx Plus Program Income Limits for 2004**
**350% Federal Poverty Level**
(Federal Poverty Level may change after 12/31/04)

| Family Size | Annual Gross Income | Family Size | Annual Gross Income |
|---|---|---|---|
| 1 | $37,464 | 9 | $139,944 |
| 2 | $50,268 | 10 | $152,748 |
| 3 | $63,084 | 11 | $165,564 |
| 4 | $75,888 | 12 | $178,368 |
| 5 | $88,704 | 13 | $191,184 |
| 6 | $101,508 | 14 | $203,988 |
| 7 | $114,324 | 15 | $216,804 |
| 8 | $127,128 | For Each Additional Family Member Add: | $12,804 |

**Regular insurance is usually better than a drug discount program such as the Hawaii Rx Plus Program, so please keep any drug insurance that you may have and apply for the Hawaii Rx Plus discount card, too.**

## HAWAII Rx PLUS PROGRAM RIGHTS AND RESPONSIBILITIES

**I understand and agree to the following:**

1. This application is only a request to participate in the Hawaii Rx Plus Program.
2. Federal and State laws do not allow the Department of Human Services (DHS) to release any information I have provided without my written permission unless it is directly related to the running of the Hawaii Rx Plus Program.
3. I have the right to be treated with dignity and respect without regard to my race, color, age, sex, national origin, physical or mental disability, or religious or political beliefs.
4. I am able to request access to sign or foreign language interpreters, large print, taped materials, or accessible parking, etc., at no charge, if requested ahead of time.
5. The State may conduct independent verification of the statements I made on the application.
6. I have the right to appeal decisions concerning my eligibility or provision of benefits.
7. I agree to cooperate with the DHS, its agents and contractors, and/or auditors if my case is reviewed.
8. I understand that I must report changes in my household income, family composition, or place of residence to the Hawaii Rx Plus Program within 10 days of the change.

You may fax, mail, or bring the completed and signed application form to our office. Our fax number is (808) 692-7989 and our mailing and street addresses are:

Mailing Address: Department of Human Services
Hawaii Rx Plus Program
P.O. Box 700220
Kapolei, Hawaii 96709-0220

Street Address: Department of Human Services
Hawaii Rx Plus Program
1001 Kamokila Blvd., Suite 317
Kapolei, Hawaii 96709

DHS office hours are Monday through Friday, 7:45 a.m. to 4:30 p.m. The office is closed on State holidays. If you have any questions about the Hawaii Rx Plus Program, you may call **211**. The phone call is free, confidential, and 24/7 from all islands. You may also visit our web site at www.HawaiiRxPlus.com.

## Bilingual and Sign Interpreter Services

| | | |
|---|---|---|
| ☐ | Med-QUEST will provide a free bilingual or sign language interpreter.<br>Yes, I need a _____ language interpreter. | English |
| ☐ | Med-QUEST 將會供給您一位免費的雙語翻譯員或手勢語的翻譯員。<br>是，我要一位 (選一個) ☐普通話 / 國語 (M) ☐廣東話 (C) 的翻譯員。 | Chinese |
| ☐ | Med-QUEST epwe aora emon chon affou ese kamo, mei sinenap non poraus are pomwen poraus.<br>U, U-mochen emon chon affou non kapasen chuuk. | Chuukese |
| ☐ | E kōkua a hāʻawi ana ʻo Med-QUEST i kekahi kanaka unuhi ʻōlelo a i ʻole i kekahi kanaka “sign language.”<br>ʻAe, makemake au i kekahi kanaka unuhi ʻōlelo. | Hawaiian |
| ☐ | Ti Med-QUEST mangted iti libre nga interprete nga makaammo iti nadumaduma a pagsasao (bilingual) wenno pagsasao babaen iti senyal (sign).<br>Wen, masapul ko ti interprete nga Ilokano. | Ilocano |
| ☐ | Med-QUEST 에서는 통역이나 수화 통역사를 무료로 제공 합니다.<br>네, 저는 한국 통역이 필요 합니다. | Korean |
| ☐ | クエストが、無料で、バイリンガルあるいは手話の通訳をつけてくれます。<br>はい、私は日本語の通訳が必要です。 | Japanese |
| ☐ | Med-QUEST ຈະຈັດຫາ ນາຍພາສາ ທີ່ເວົ້າໄດ້ສອງພາສາ ຫລື ນາຍພາສາທີ່ໃ ໃຫ້ຟຣີ.<br>ແມ່ນແລ້ວ, ຂ້າພະເຈົ້າ ຕ້ອງການ ນາຍພາສາລາວ. | Laotian |
| ☐ | Med-QUEST enaj lewōj ejelok wōnen juōn rukok ak rukok kin sign.<br>Aet, iaikuj i juōn rukok kajin majōl. | Marshallese |
| ☐ | Med-QUEST pahn kahk sawasikida sewesepehn tohn kawehwei ni sohte pweipwei.<br>Ehi, ih anahne tohn kawehwei ohng ni lokoiahn Pohnpeian. | Pohnpeian |
| ☐ | O le a saunia ele Med-QUEST se faamatala upu ile gagana poo le faaaogaina o saini ma lima e aunoa mase totogi.<br>Ioe, oute manaomia se faamatala upu ile gagana Samoa. | Samoan |
| ☐ | Med-QUEST le proporcionará un intérprete sin cargo bilingüe o de lenguaje de signos.<br>Sí, necesito un intérprete de español. | Spanish |
| ☐ | Ang Med-QUEST ay nagbibigay ng libreng interprete na makakaalam ng iba-ibang wika (bilingual) o lenggwahe sa pamamagitan ng senyas (sign).<br>Oo, kailangan ko ang interprete na Tagalog. | Tagalog |
| ☐ | ʻE lava heʻe Med-QUEST ʻo ʻomai e kau fakatonulea ʻo tatau pe kihe lea moe fakaʻilonga lea ʻaki e nima.<br>ʻIo ʻoku ou fiemaʻu e fakatonulea. | Tongan |
| ☐ | Med-QUEST sẽ cung cấp một thông dịch viên song ngữ hoặc thông dịch viên ra dấu miễn phí.<br>Vâng, tôi cần một thông dịch viên tiếng Việt Nam. | Vietnamese |